

# 高雄榮民總醫院

## 皮膚癌(BCC)診療原則

修訂日期:2025.05.20



# BCC診療指引審視修訂會議討論日期

● 上次會議： 2024/04/19

上一版	新版
NCCN Guidelines 2024年版	更換附件為:NCCN Guidelines 2025年版





### STRATIFICATION TO DETERMINE TREATMENT OPTIONS FOR LOCAL BCC BASED ON RISK FACTORS FOR RECURRENCE<sup>a</sup>

Risk Group	Low Risk	High Risk
Treatment options	<a href="#">BCC-2</a>	頭頸/手足/ <b>pretibia</b> /肛生殖區 = 高風險 (與大小無關)
<b>H&amp;P</b>		
Location/diameter (cm)	Trunk, extremities <2 cm	Trunk, extremities ≥2 cm Head, neck, hands, feet, pretibial, and anogenital area (any size) <sup>b</sup>
Clinical borders	Well-defined	Poorly-defined
Primary vs. recurrent	Primary	Recurrent
Immunosuppression	(-)	(+)
Site of prior RT	(-)	(+)
<b>Pathology (<a href="#">BCC-A</a>)</b>		
Histologic subtype	Nodular, superficial <sup>c</sup>	Aggressive growth pattern <sup>d</sup>
Perineural involvement	(-)	(+)

特殊亞型  
**Basosquamous**  
**Infiltrative**  
**micronodular**  
**morpheaform**

<sup>a</sup> Any high-risk factor places the patient in the high-risk category.

<sup>b</sup> Narrow excision margins due to anatomic and functional constraints are associated with increased recurrence rates with standard histologic processing. Complete margin assessment with Mohs/PDEMA is recommended. For tumors <6 mm in size, without other high-risk features, other treatment modalities may be considered if at least 4-mm clinically tumor-free margins can be obtained without significant anatomic or functional distortions.

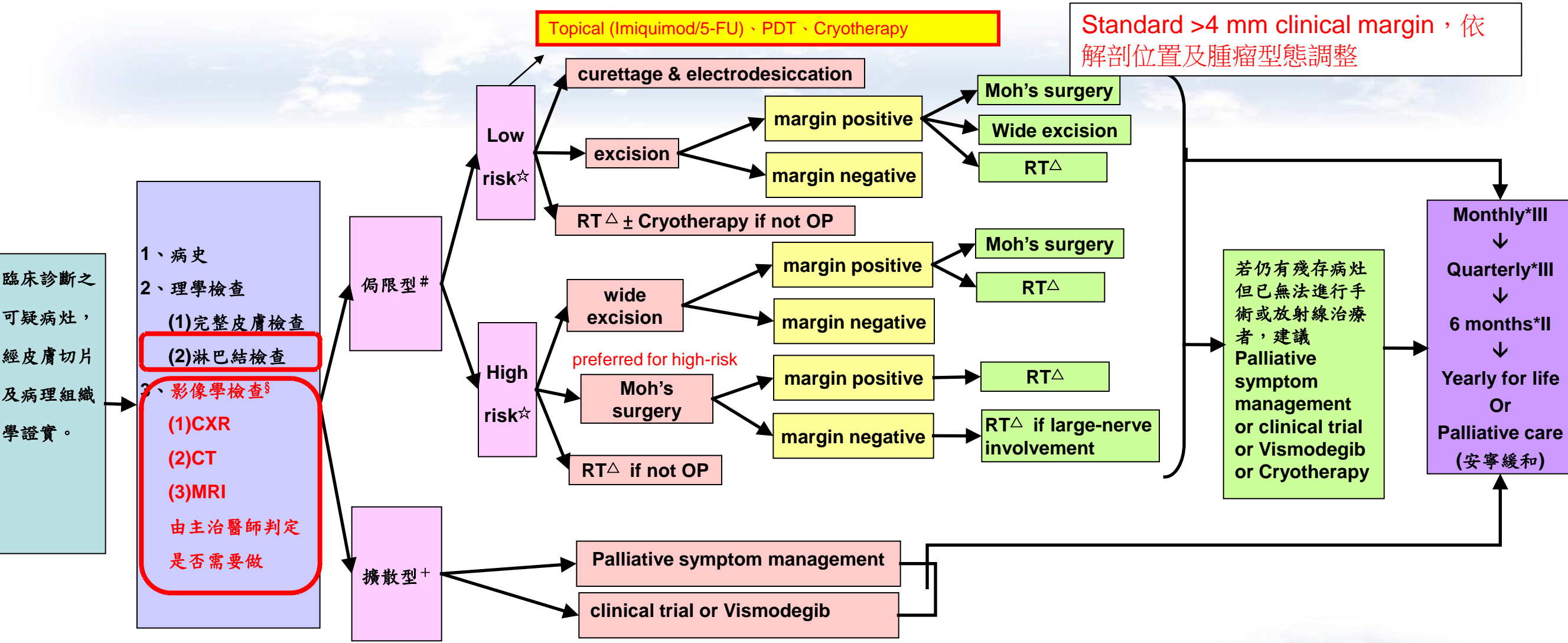
<sup>c</sup> Low-risk ~~nodular, superficial, and pigmented~~ aggressive growth patterns such as keratotic, infundibulocystic, and fibroepithelioma of Pinkus.

<sup>d</sup> Having **basosquamous, infiltrative, sclerosing/morpheaform, micronodular,** and BCC with carcinosarcomatous differentiation features in any portion of the tumor. In some cases, basosquamous tumors may be prognostically similar to squamous cell carcinoma (SCC); clinicopathologic correlation is recommended in these cases to further consider prognostic implication.

Note: All recommendations are category 2A unless otherwise indicated.

# 基底細胞癌(BCC)

診斷	初步評估	分期	初始治療	療效評估	輔助治療	追蹤
----	------	----	------	------	------	----



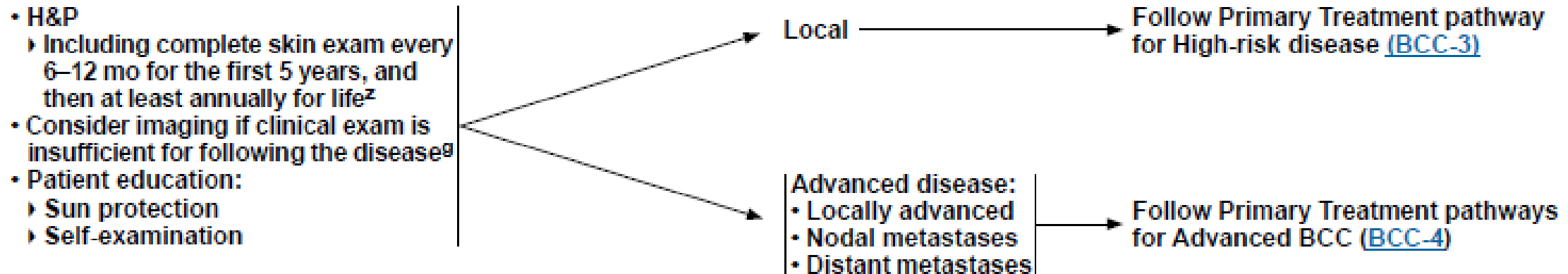
HHI: Vismodegib/Sonidegib  
Cemiplimab (PD-1 inhibitor) : HHI失敗或不耐  
<本院暫無藥品>

§ : Image studies is indicated for extensive disease (deep structural involvement such as bone, deep soft tissue, perineural disease)  
 + : regional or distal metastatic disease(初始皮膚病灶治療同侷限型)  
 ☆ : 附件一  
 △ : 附件二  
 # : T any, N0, M0(附件三)



### FOLLOW-UP

### RECURRENCE



### NCCN 2025 明確建議：

q6–12 個月 × 5 年，之後至少每年一次，終身追蹤

<因本院病患皆為比較高齡患者，故追蹤維持 **Monthly\*||Quarterly\*||6 months\*||Yearly for life**>

### 高風險族群（必須標註需皮膚科嚴格追蹤）：

- 移植病人
- 5 年內曾罹患黑色素瘤
- 5 年內有 ≥4 次 NMSC

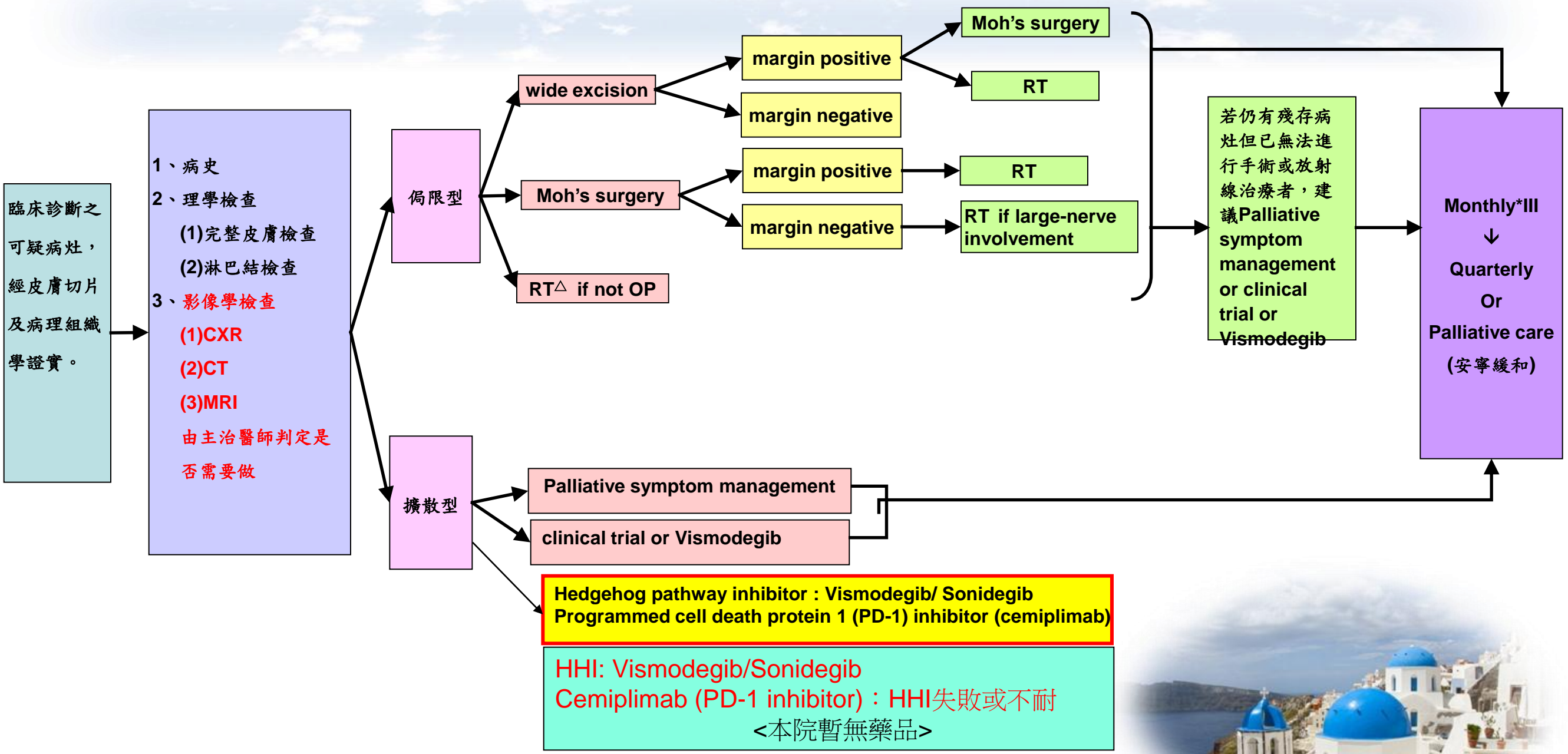
<sup>9</sup> Imaging modality and targeted area should be at the discretion of the treating team based on the suspected extent of disease (ie, local, regional, metastatic). Histologic confirmation is sufficient to diagnose local recurrence, but MRI with and without contrast can be considered to assess extent of local disease. For nodal or distant metastasis, histologic analysis and/or CT imaging can be used for confirmation and to gauge extent of disease.

<sup>2</sup> Follow-up with a dermatologist is strongly recommended if any of the following criteria are met: past or imminent solid organ, marrow, or hematopoietic cell transplant; one or more cutaneous melanomas in the past 5 years; or four or more non-melanoma skin cancers in the past 5 years.

Note: All recommendations are category 2A unless otherwise indicated.

# 基底細胞癌(BCC)

## 復發



皮膚癌  
多專科團隊

# 基底細胞癌(BCC)

## 癌症藥物停藥準則

- 根據CTCAE (Common Terminology Criteria for Adverse Events, Version 4.0 Published: May 28, 2009 【v4.03: June 14, 2010】)，出現Grade 3 ~ Grade 4 adverse event。
- 停藥至adverse event回復至Grade 1或Baseline時可再次用藥，但有些患者必須調整用藥劑量。
- 特定藥物治療下疾病仍持續進展，根據追蹤及評估顯示疾病對此特定藥物治療無效 (考慮停止投藥並選擇其他治療方法)。
- 病患要求 ( Hospice care或其他因素)。
- 病患死亡。



# 基底細胞癌(BCC)

附件一：

**STRATIFICATION TO DETERMINE TREATMENT OPTIONS FOR LOCAL BCC BASED ON RISK FACTORS FOR RECURRENCE<sup>a</sup>**

Risk Group	Low Risk	High Risk
Treatment options	<a href="#">BCC-2</a>	<a href="#">BCC-3</a>
<b>H&amp;P</b>		
Location/diameter (cm)	Trunk, extremities <2 cm	Trunk, extremities ≥2 cm Head, neck, hands, feet, pretibial, and anogenital area (any size) <sup>b</sup>
Clinical borders	Well-defined	Poorly-defined
Primary vs. recurrent	Primary	Recurrent
Immunosuppression	(-)	(+)
Site of prior RT	(-)	(+)
<b>Pathology (BCC-A)</b>		
Histologic subtype	Nodular, superficial <sup>c</sup>	Aggressive growth pattern <sup>d</sup>
Perineural involvement	(-)	(+)


<sup>a</sup> Any high-risk factor places the patient in the high-risk category.  
<sup>b</sup> Narrow excision margins due to anatomic and functional constraints are associated with increased recurrence rates with standard histologic processing. Complete margin assessment with Mohs/PDEMA is recommended. For tumors <6 mm in size, without other high-risk features, other treatment modalities may be considered if at least 4-mm clinically tumor-free margins can be obtained without significant anatomic or functional distortions.  
<sup>c</sup> Low-risk histologic subtypes include nodular, superficial, and other non-aggressive growth patterns such as keratotic, infundibulocystic, and fibroepithelioma of Pinkus.  
<sup>d</sup> Having basosquamous, infiltrative, sclerosing/morpheaform, micronodular, and BCC with carcinosarcomatous differentiation features in any portion of the tumor. In some cases, basosquamous tumors may be prognostically similar to squamous cell carcinoma (SCC); clinicopathologic correlation is recommended in these cases to further consider prognostic implication.

**Note:** All recommendations are category 2A unless otherwise indicated.



# 基底細胞癌(BCC)

附件二:



National Comprehensive Cancer Network®

## NCCN Guidelines Version 2.2025 Basal Cell Skin Cancer

[NCCN Guidelines Index](#)  
[Table of Contents](#)  
[Discussion](#)

---

**PRINCIPLES OF RADIATION THERAPY**

**General Principles**

- Refer to the [ASTRO Guideline on Definitive and Postoperative Radiation Therapy for Basal and Squamous Cell Cancers of the Skin<sup>1</sup>](#) for general indications and dose recommendations.
- Protracted fractionation is associated with improved cosmetic results and should be utilized for poorly vascularized or cartilaginous areas.
- RT is contraindicated for genetic conditions predisposing to skin cancer (eg, basal cell nevus syndrome and relatively contraindicated for patients with connective tissue diseases (eg, scleroderma).
- Given higher complication rates, reirradiation should not be routinely utilized for recurrent disease within a prior radiation field.
- Isotope-based brachytherapy can be an effective treatment for certain sites of disease, particularly on the head and neck.<sup>a</sup>
- There are insufficient long-term efficacy and safety data to support the routine use of electronic surface brachytherapy.<sup>a</sup>
- Image-guided radiation therapy (IGRT) is considered best practice when treating with intensity-modulated radiation therapy (IMRT), proton beam radiotherapy, or 3-D conformal radiation. The use of IGRT for other types of radiotherapy to treat skin cancer is considered unnecessary.<sup>a</sup>
- Radiation treatments should be given by a practicing radiation oncologist with radiation physics support to meet established quality assurance and dosimetric constraints.

Primary Tumor	RT Dosing
Definitive RT	BED10 of 70–93 Gy for conventional fractionation BED10 of 56–88 Gy for hypofractionation
Postoperative adjuvant RT	BED10 of 60–79 Gy for conventional fractionation BED10 of 56–70 Gy for hypofractionation
<b>Regional Disease</b>	
<ul style="list-style-type: none"> <li>Lymph node regions, after lymph node dissection                             <ul style="list-style-type: none"> <li>Negative margins, no extranodal extension (ENE)</li> <li>Positive margins or ENE</li> </ul> </li> </ul>	50–60 Gy over 5 to 6 weeks 60–66 Gy over 6 to 7 weeks
<ul style="list-style-type: none"> <li>Lymph node regions, without lymph node dissection                             <ul style="list-style-type: none"> <li>Clinically positive</li> </ul> </li> </ul>	60–70 Gy over 6 to 7 weeks
<ul style="list-style-type: none"> <li>Clinically at-risk nerves</li> </ul>	50–60 Gy over 5 to 6 weeks

- BED = Biologically effective dose
- Conventionally fractionated radiotherapy consists of five daily treatments per week.
- Hypofractionated radiotherapy consists of daily treatments or two to four treatments per week. Fraction sizes larger than 6 Gy are not routinely recommended outside of the palliative setting.

**Footnote**  
<sup>a</sup> See [Discussion](#)

**Reference**  
<sup>1</sup> Likhacheva A, Awan M, Barker CA, et al. Definitive and Postoperative Radiation Therapy for Basal and Squamous Cell Cancers of the Skin: Executive Summary of an American Society for Radiation Oncology Clinical Practice Guideline. *Pract Radiat Oncol* 2020;10:8-20.

Note: All recommendations are category 2A unless otherwise indicated.



# Reference

1. NCCN Clinical Practice Guideline in Oncology, Basal and Squamous Cell Skin Cancers, Version 1.2025.
2. G Ital Dermatol Venereol. 2016 Feb;151(1):77-86. Epub 2014 Jun 30. Treatments of advanced basal cell carcinoma: a review of the literature.
3. Sekulic A, Migden MR, Basset-Seguín N, et al. Long-term safety and efficacy of vismodegib in patients with advanced basal cell carcinoma (aBCC): 18-month update of the pivotal ERIVANCE BCC study. ASCO Meeting Abstracts 2013;31:9037.
4. Mendenhall WM, Ferlito A, Takes RP, et al. Cutaneous head and neck basal and squamous cell carcinomas with perineural invasion. Oral Oncol 2012;48:918-922.
5. Sekulic A, Migden MR, Oro AE, et al. Efficacy and safety of vismodegib in advanced basal-cell carcinoma. N Engl J Med 2012;366:2171-2179.
6. Lott DG, Manz R, Koch C, Lorenz RR. Aggressive behavior of nonmelanotic skin cancers in solid organ transplant recipients. Transplantation 2010;90:683-687.
7. Basosquamous carcinoma. J Am Acad Dermatol 2009;60:137-143.
8. Mendenhall WM, Amdur RJ, Hinerman RW, et al. Radiotherapy for cutaneous squamous and basal cell carcinomas of the head and neck. Laryngoscope 2009;119:1994-1999.
9. Mosterd K, Krekels GA, Nieman FH, et al. Surgical excision versus Mohs' micrographic surgery for primary and recurrent basal-cell carcinoma of the face: a prospective randomised controlled trial with 5-years' follow-up. Lancet Oncol 2008;9:1149-1156.
10. Neville JA, Welch E, Leffell DJ. Management of nonmelanoma skin cancer in 2007. Nat Clin Pract Oncol 2007;4:462-469.
11. Rodriguez-Vigil T, Vazquez-Lopez F, Perez-Oliva N. Recurrence rates of primary basal cell carcinoma in facial risk areas treated with curettage and electrodesiccation. J Am Acad Dermatol 2007;56:91-95.
12. Rubin AI, Chen EH, Ratner D. Basal-cell carcinoma. N Engl J Med 2005;353:2262-2269.
13. Bath-Hextall F, Bong J, Perkins W, Williams H. Interventions for basal cell carcinoma of the skin: systematic review. BMJ 2004;329:705.